

# WASATCH COUNTY HOSPITAL

## Admission Sheet

Hospital No. 6 585Full Name Luther Martin RhodesNearest Rel. J. Robert RhodesAddress 761 No 1050 East  
Provo, Utah

Address \_\_\_\_\_

Relation to Patient GrandsonDate 9-27-74 Room No. \_\_\_\_\_

Telephone \_\_\_\_\_

Hour 11:00 AM PM Religion \_\_\_\_\_Responsible Party selfDate of Birth 4/03/91 Age 80Hospital Ins. MedicareM S W D Sex M

Policy No. Welfare \_\_\_\_\_

Occupation \_\_\_\_\_

Contract \_\_\_\_\_

Doctor Rhodes

Group \_\_\_\_\_

Medicare 538-30-6696-AAdmitted to: Med Surg OB

Employer \_\_\_\_\_

Prev. Hospitalization here: Yes No

Employer's Address \_\_\_\_\_

### The following only for Obstetrical Cases

Father's Full Name \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_

Present Address \_\_\_\_\_ Birthplace \_\_\_\_\_

Mother's Birthplace \_\_\_\_\_

Remarks \_\_\_\_\_

### CONSENT TO MEDICAL and/or SURGICAL TREATMENT

Heber City, Utah 9-27-7411:00 AM PM

I hereby authorize the Physician in charge of the care of Luther M. Rhodes to administer any treatment, or to administer such anesthetics and perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Sig. of Patient \_\_\_\_\_ Nearest Rel. J. Robert RhodesWitness Marjorie McKinnon Relationship to Pt. \_\_\_\_\_

This consent must be signed by the patient, or if the patient is a minor or not competent to give legal consent, by the nearest relative, or failing a relative, by the nearest friend.

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Wasatch County Hospital to release the information requested by the Insurance Companies.

Date \_\_\_\_\_ Signed \_\_\_\_\_

Patient (Parent if Minor)

### AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment directly to the Wasatch County Hospital of the Policy Benefits therein specified and otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I understand that I am financially responsible to the hospital for charges not covered by this authorization.

Date \_\_\_\_\_ Signed \_\_\_\_\_

Policyholder

# WASATCH COUNTY HOSPITAL

## Admission Sheet

Hospital No. 6 585

Name Luther Martin Rhodes Nearest Rel. J. Robert Rhodes  
Address 761 No 1050 East  
Provo, Utah  
Relation to Patient Grandson  
Date 9-27-74 Room No. \_\_\_\_\_ Telephone \_\_\_\_\_  
Time 11:00 AM PM Religion \_\_\_\_\_ Responsible Party self  
Date of Birth 4/03/91 Age 80 Hospital Ins. Medicare  
Sex M Policy No. Welfare \_\_\_\_\_  
Occupation \_\_\_\_\_ Contract \_\_\_\_\_  
Group \_\_\_\_\_  
Signature Rhodes Medicare 538-30-6696-A  
Admitted to: Med Surg OB Employer \_\_\_\_\_  
Hospitalization here: Yes No Employer's Address \_\_\_\_\_

### The following only for Obstetrical Cases

Father's Full Name \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_  
Present Address \_\_\_\_\_ Birthplace \_\_\_\_\_  
Mother's Birthplace \_\_\_\_\_  
Remarks \_\_\_\_\_

### CONSENT TO MEDICAL and/or SURGICAL TREATMENT

Heber City, Utah 9-27-74 11:00 AM PM

I hereby authorize the Physician in charge of the care of Luther M. Rhodes  
to administer any treatment, or to administer such anesthetics and perform such operations as may be deemed  
necessary or advisable in the diagnosis and treatment of this patient.

Name of Patient \_\_\_\_\_ Nearest Rel. Maureen M. Kinnaman  
Relationship to Pt. \_\_\_\_\_  
This consent must be signed by the patient, or if the patient is a minor or not competent to give legal consent,  
the nearest relative, or failing a relative, by the nearest friend.

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Wasatch County Hospital to release the information requested by the Insurance Com-  
panies.

Date \_\_\_\_\_ Signed \_\_\_\_\_ Patient (Parent if Minor)

### AUTHORIZATION TO PAY INSURANCE BENEFITS

I hereby authorize payment directly to the Wasatch County Hospital of the Policy Benefits therein specified and  
otherwise payable to me, but not to exceed the hospital's regular charges for this period of hospitalization. I  
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Date \_\_\_\_\_ Signed \_\_\_\_\_ Policyholder